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State Commission on the Efficacy of CON

October 24, 2005

Presentation by Thomas R. Gadacz, M.D., F.A.C.S.

Governor from Georgia

**American College of Surgeons** 

### State Commission on the Efficacy of CON October 24, 2005 Presentation by Thomas R. Gadacz, M.D., F.A.C.S.

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# Beorgia Chapter American College of Surgeons

Statement of the Georgia Chapter, American College of Surgeons

to the

State Commission on the Efficacy of the Certificate of Need Program

Presented by

Thomas R. Gadacz, MD, FACS
Professor Emeritus
Department of Surgery
Medical College of Georgia
Augusta, Georgia

Statement on General Surgery as a Single Specialty

Monday, October 24, 2005

Dr. Rahn, and members of the State Commission on the Efficacy of the Certificate of Need Program, my name is Thomas Gadacz, MD, FACS. I am a general surgeon from Evans, Georgia, and Professor Emeritus of the Department of Surgery at the Medical College of Georgia (MCG) in Augusta. From 1991 to 2005 I served as Professor and Chairman of the Department of Surgery at the MCG, and also served as the Director of the Surgical Residency Program during that time. Prior to that, I was a Professor of Surgery at The Johns Hopkins Hospital. I am a Board-certified general surgeon, and received this certification in 1975 from the American Board of Surgery.

I am here today in my role as a Governor from the Georgia Chapter of the American College of Surgeons, and am proud to represent the 1627 members of the Chapter. I also represent the American College of Surgeons, which is a voluntary, educational and scientific organization devoted to the ethical and competent practice of surgery, and to enhancing the quality of care provided to surgical patients. For over 90 years, the College has disseminated medical and surgical information to the profession and to the general public, and it has been deeply involved in establishing standards of practice. With over 66,000 members, nearly half of which are general surgeons, the ACS is the largest surgical association in the world.

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Over the course of the past few years, an issue has arisen in our state relating to the Certificate of Need (CON) law and how the specialty of general surgery is defined. There has been some confusion over this definition, which currently describes general surgery as a multi-specialty for purposes of acquiring an exemption from the CON requirements for ambulatory surgery centers. My intention is to clear up this confusion by providing an accurate definition of general surgery and by describing the training that general surgeons go through in order to become general surgeons.

It is universally recognized by academic and private healthcare institutions that general surgery is a distinct single medical specialty, just as unique and focused as any other single medical specialty. Although the term "general" is in the title of general surgery, it does not imply that surgeons in this specialty area: practice multi-specialties; are primary care physicians; perform every type of surgical procedure; or have no specialty status. Just the opposite is true

Individuals entering careers and training programs in general surgery complete an undergraduate degree with specific science courses. They must have an MD/DO degree from an approved medical school before moving on to specialize in this area. They apply to general surgery residency programs, and if accepted, undergo a minimum of five years of training in the specialty. This training is geared to educate the residents in the essential components of general surgery, including surgery of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and the endocrine system. It also includes the comprehensive management of trauma, burns, emergency surgery and surgical critical care.

Most general surgeons in this country have the above special training and expertise tested when they receive certification through the American Board of Surgery, with recertification required every seven years. This certification process parallels those of other medical specialties that also have defined areas of practice. In fact, hospitals consider general surgery as a single specialty for purposes of their physician recruitment, credentialing and granting of privileges for surgical procedures. Healthcare insurers also consider general surgery a single specialty practice as evidenced by reimbursement for specific types of procedures provided by the specialty.

Other organizations recognize general surgery as a single specialty. These include, in addition to the American Board of Surgery, the American Board of Medical Specialties (ABMS), the American Medical Association, and of course the Georgia Chapter of the ACS and the Georgia Surgical Society. In fact, the ABMS, which is composed of 24 member specialty boards, recognizes other specialties as single specialties, including: orthopaedics, plastic surgery, colon & rectal surgery, urology, thoracic surgery, and anesthesiology.

On November 21, 2003 the Department of Community Health and the Health Strategies Council adopted an inaccurate definition of General Surgery. The source of this definition is the American Society of General Surgeons however this definition cannot be verified from their website. I am recommending that this committee go on record rectifying this error and recognize General Surgery as a Single Specialty.

In conclusion, the evidence is clear: general surgery is a single specialty and should be recognized as such by our state. I would ask that this Commission, as part of it's deliberations of the CON program, adopt the definition of general surgery as defined by the ABS and recognized by the ABMS and other well-known medical organizations. In addition, other Boarded specialties should not be included under the parameters of general surgery. The recognition of a medical specialty should be based on ABMS and other well recognized and standard criteria.

Thank you for the opportunity to appear before you today; I would be happy to answer any questions you have. I would also like to offer my assistance to this Commission and the Department of Community Health.

August 23, 2005

Thomas R. Gadacz, M.D., F.A.C.S. Governor, American College of Surgeons 4205 Ascot Court Evans, GA 30809

#### Dear Tom:

You wrote to inquire about the status of general surgery as a specialty, and whether it constituted a single specialty or multiple specialties. The answer is that it is a single specialty which encompasses four subspecialties within its rubric – pediatric surgery, vascular surgery, surgical critical care, and surgery of the hand. (Vascular surgery is on the way to becoming a specialty in its own right, rather than a subspecialty, and that action has already been approved by the American Board of Surgery (ABS)). Let me elaborate on the basis of this statement.

The oversight and official approval for all medical specialty boards in the United States is done by a private non-profit organization known as the American Board of Medical Specialties (ABMS), located in Chicago. They have an elaborate set of bylaws which regulates the development and approval of new specialty boards, and this is subject to a convoluted process that takes at least a year to complete. (A copy of those bylaws relevant to the designation of new specialties is enclosed for your reference.) No other recognized organization has any role in the official designation of a medical specialty, and it is an area where there is no government involvement. Thus, the "official" word as to which specialties are recognized and legitimate is that of the ABMS, and indeed the addendum "ABMS approved Boards" is often the term used to refer to the officially designated boards. There are a total of 24 independent boards (and approximately 32 independent specialties, since some boards manage more than one independent specialty certificate). There are more than 100 subspecialties encompassed within the 24 boards.

The American Board of Surgery was organized and incorporated in 1937 and has been recognized as an independent board by the ABMS (or its precursor organization) since that time. From 1937 until 1976 only the certificate in general surgery was awarded. In 1976 the subspecialty certificate in pediatric surgery was added, in 1982 the certificate in vascular surgery, in 1989 the certificate in surgery of the hand, and in 1991 the certificate in surgical critical care.

The ABMS does not differentiate among the 24 member boards – all are co-equal and have equivalent status in awarding specialty certificates. Thus, there is no difference between one "specialty" and another. General surgery is therefore coequal to internal medicine, pediatrics, radiology, pathology, etc. and does not have different status. At

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Thomas R. Gadacz, M.D. August 23, 2005

the same time, cardiology, gastroenterology, infections diseases, etc., are subspecialties of internal medicine and are therefore equivalent to pediatric surgery, surgical critical care, etc., which are subspecialties of surgery. For purposes such as you have outlined, the use of the terms "specialty" and "subspecialty" are relatively interchangeable in public use, although they have specific definitions and differences in the world of ABMS.

I hope the above information clarifies your situation and provides what you need in regard to the status of general surgery. If you need an opinion from the ABMS directly, I'm sure they would provide that and confirm the above information. The President of the ABMS is Dr. Stephen H. Miller, M.D., M.P.H., and his address is American Board of Medical Specialties, 1007 Church St., Suite 404, Evanston, IL, 60201-5913.

Sincerely,

Trul

Frank R. Lewis, Jr., M.D. Executive Director

Enc.

cc: Paul Collicott, M.D.

American College of Surgeons



#### Specialty of Surgery (General Surgery) Defined

The ABS interprets the term "general surgery" in a comprehensive yet specific manner, as a discipline having a central core of knowledge embracing anatomy, physiology, metabolism, immunology, nutrition, pathology, wound healing, shock and resuscitation, intensive care and neoplasia within the essential content areas outlined below.

Surgeons certified by the American Board of Surgery have, through their training, acquired knowledge and experience related to diagnosis and preoperative, operative, and postoperative management, including the management of complications, in the essential content areas listed below.

- Alimentary Tract
- Abdomen and its Contents
- Breast, Skin and Soft Tissue
- Endocrine System
- Head and Neck Surgery
- Pediatric Surgery
- Surgical Critical Care
- Surgical Oncology
- Trauma/Burns
- Vascular Surgery

Experience in any of these content areas does not necessarily encompass its full range and complexity of procedures, particularly advanced operations and treatments of a specialized nature. This is especially true of disciplines that have residencies approved by the Accreditation Council for Graduate Medical Education (ACGME) and have processes for additional certification.

The certified general surgeon is also expected to have:

- preoperative, operative, and postoperative experience in transplantation surgery, plastic surgery (including familiarity with the role of breast reconstruction after mastectomy), and cardiothoracic surgery;
- significant experience in performing minimally invasive surgical procedures, including basic and advanced laparoscopic procedures;
- experience with endoscopic techniques, particularly proctosigmoidoscopy, colonoscopy, esophagogastroduodenoscopy, laryngoscopy, and bronchoscopy;
- experience with sentinel lymph node mapping for breast cancer and melanoma;
- experience with diagnostic ultrasonography, particularly of the following areas:
  - -head and neck;
  - -breast;
  - -abdomen, including intraoperative and laparoscopic ultrasonography;
  - -endorectal;
- knowledge and skills in palliative care and management of pain, weight loss, and cachexia in patients with malignant and chronic conditions;

- familiarity with diagnostic and therapeutic techniques related to:
  - -fine-needle aspiration techniques for cytologic biopsy;
- -investigation and manipulation of the distal common bile duct (including sphincterotomy);
  - -physiologic testing and evaluation of the gastrointestinal tract;
- -noninvasive diagnostic evaluation of the vascular system and invasive vascular interventional techniques;
- familiarity with the special requirements of bariatric and geriatric surgical patients, including operative care and counseling of patients and families;
- an understanding of the administration of anesthetic agents, airway intubation, and conscious sedation;
- an understanding of the diagnosis and management of urgent and emergent problems in gynecologic, neurological, orthopaedic, and urologic surgery.

Updated: December 29, 2004

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## APPROVAL OF NEW EXAMINING BOARDS IN MEDICAL SPECIALTIES

Since 1934, medical specialty boards have been officially approved by action of the American Board of Medical Specialties (ABMS) and the American Medical Association Council on Medical Education (AMA/CME). This determination begins with review by the Liaison Committee for Specialty Boards (LCSB), an organization sponsored by the ABMS and the AMA/CME.

The LCSB consists of four voting representatives from the ABMS Executive Committee and four voting representatives from the AMA/CME. The Chairman of the AMA/CME serves as Chairman of the LCSB. The Executive Vice President of the ABMS serves as Secretary of the LCSB (without vote). The Secretary of the AMA/CME also serves on the LCSB (without vote). The LCSB meets on the call of the Chairman at no fixed intervals, but meets annually.

The functions of the LCSB are:

- 1) to receive applications for approval as a medical specialty certifying board.
- 2) to evaluate applications according to the current version of the Essentials for Approval of Examining Boards in Medical Specialties.
- 3) to hold hearings on such applications if appropriate to do so.
- 4) to have the Secretary forward approved applications to the sponsors of the LCSB (the ABMS and the AMA) along with the recommendations of the LCSB. Both the ABMS and the AMA/CME must act affirmatively by a 2/3 majority if a new board is to be approved. LCSB is not required to ratify the actions of its sponsors.
- 5) to notify the applicant of the action of the sponsors of the LCSB. If the application is disapproved, the applicant may reapply after 12 months.

Action on applications for approval of examining boards in medical specialties is based on the Essentials for Approval of Examining Boards in Medical Specialties, a collaborative effort of the ABMS and the AMA/CME begun in 1934. The original Essentials for Approval of Examining Boards in Medical Specialties was based on recommendations of the ABMS Committee on Standards and Examinations and was approved by the AMA House of Delegates in June, 1934. The Essentials have undergone several revisions, both major and minor, since 1934. The present eleventh revision of the Essentials is a joint document approved by both organizations. It embodies the policies of both the ABMS and the AMA pertaining to specialty boards while retaining each organization's privilege of independent consideration and action. The Essentials describe the standards and procedures by which applications for approval of new examining boards are evaluated.

The approved specialty boards and the current list of categories of certification in each of those specialties are listed on the inside front cover and in Table 1 of this edition of the ABMS Annual Report and Reference Handbook.

# ELEVENTH REVISION OF ESSENTIALS FOR APPROVAL OF EXAMINING BOARDS IN MEDICAL SPECIALTIES

Approved by the ABMS\* March 2000 and CME/AMA FEBRUARY 2000 Approved by the House of Delegates of the AMA in June 2000

#### Section I. Function of the Liaison Committee for Specialty Boards (LCSB)

The American Board of Medical Specialties (ABMS) by authority of its Member Boards and other member organizations, and the American Medical Association Council on Medical Education (AMA/CME), by authority delegated by the AMA House of Delegates, have established the LCSB consisting of four representatives selected from each body. The Chairman of the AMA/CME shall be the Chairman of the LCSB. The Executive Vice President of the ABMS shall be the Secretary of the LCSB but shall not vote. The Secretary of the AMA/CME shall attend meetings of the LCSB but shall not vote.

The purpose of the Liaison Committee is:

- To receive applications for approval of medical specialty boards and make recommendations to its parent bodies.
- B. To provide a mechanism for contact with petitioning groups through the Secretary of the LCSB on matters related to approval of new specialty boards and for transmission of decisions of the ABMS and the AMA/CME to applicants.
- C. To determine as expeditiously as possible if the applicant board has complied with the Essentials for approval.

To assist in attaining these objectives, the LCSB is authorized to appoint consultants known to the ABMS and the AMA/CME to be qualified and knowledgeable in the special field which the new specialty board intends to represent.

#### Section II. Definition of a Specialty Board

A specialty board is a separately incorporated, financially independent body which determines its requirements and policies for certification, selects the members of its governing body in accordance with the procedures stipulated in its bylaws, accepts its candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who submit to and pass its evaluations.

#### Section III. Objectives and Functions of Specialty Boards

A fundamental objective of all approved boards is to act in the public interest by contributing to the improvement of medical care by establishing the qualifications for candidates and by evaluating individuals who apply for certification

The primary function of all approved specialty boards is to evaluate the qualifications of candidates who apply and to certify as Diplomates those who are found to be qualified.

To accomplish this function, specialty boards shall:

- A. Determine whether or not candidates have received adequate preparation in accord with educational standards established by the specialty board.
- B. Conduct comprehensive evaluations of the knowledge and experience of such candidates, and
- C. Issue certificates to those physicians found qualified under the stated requirements of the board.

A related function of approved specialty boards is to assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training in collaboration with other concerned organizations and agencies.

#### Section IV. Criteria for Approval of New Examining Boards

- A. The establishment of a new specialty board signifies the differentiation of a new specialty which must be based on major new concepts in medical science.
- B. A new medical specialty board must represent a distinct and well-defined field of medical practice. It may entail special concern with the problems of patients according to age, sex, or organ systems or with the interaction between patients and their environment.
  - A new certifying board must be based on substantial advancement in medical science. The needed training must be sufficiently complex or extended that it is not feasible to include it in established training programs.
- C. A specialty board must require evidence that its diplomates have acquired capability in a stated area of medicine and will demonstrate special knowledge in that field.
- D. A plan must be presented whereby preparatory programs in graduate medical education will be developed for accreditation by the Accreditation Council for Graduate Medical Education (ACGME). New boards may be permitted under conditions stated by the petitioning board and approved by the LCSB, to approve training or experience or a combination of both as equivalent to that acquired in accredited training programs until accreditation by the ACGME is in place.

- E. The applicant must present satisfactory evidence that the proposal has broad professional support in the field of medical practice making application to become an ABMS certifying board, and that approval will promote and enhance recognition of a single standard in preparation for practice in that field.
- F. In order to promote public and professional understanding and recognition of a single standard in each specialty and to promote efficiency of the evaluation process, only one certifying board will be recognized in each specialty.
- G. While it is recognized that considerable variation among certifying boards may be permitted, the operational plan must include satisfactory details in the following areas:
  - (1) Names, professional affiliations and professional accomplishments of the sponsors.
  - (2) Structure—the composition of the board should provide for representation of appropriate organizations and for effective operation of the board.
  - (3) Content of the field—data from a detailed analysis of the professional area, including present and future public needs and professional interests should be presented. Such analysis should be used for development and continued evaluation of standards for certification.
  - (4) While requirements may not be fully developed at the date of application, a plan for development and validation of the requirements should be presented.
  - (5) A detailed plan for evaluating individual candidates should be presented.
  - (6) The financial support for a valid, objective program of candidate evaluation, as well as other necessary activities in graduate education must be included in the plan. The data presented should include projected numbers of potential diplomates and projected certification fees.

#### Section V. Procedure for Approval of New Specialty Boards

- A. The application should be directed to the Secretary of the LCSB who also serves as Executive Vice President of the ABMS.
- B. The LCSB may conduct a hearing before making a recommendation on any application.
- C. The application should adhere to the following outline:
  - (1) The name of the proposed specialty board asking for approval.
  - (2) The proposed objectives and function of the petitioning board.
  - (3) The names of the sponsoring organizations.
  - (4) A detailed statement describing how compliance with each of the criteria in Section IV is achieved.
  - (5) A description of the proposed organization, the names and professional qualifications of the proposed officials, the names and addresses of the founding members, their qualifications, and the organization which each member represents.
  - (6) A copy of the proposed or existing Constitution and Bylaws.
  - (7) A copy of the proposed or existing Articles of Incorporation.
  - (8) An outline of the qualifications to be required of applicants for certification.
  - (9) The number and names of institutions providing residency or other acceptable training programs in the specialty, the total number of residencies available, and the number of residency training programs that can be developed.
  - (10) The approximate number of physicians engaged in the practice of the specialty.
  - (11) A copy of the proposed application form for candidates for certification.
  - (12) Provisions, if any, for certifying physicians practicing in the specialty without examination or accredited training. The statement should include the qualifications and the number of physicians to be certified in that manner.
- D. The responsibility of the LCSB is not limited to initial evaluation of the certifying boards in medical specialties. Proposed changes in policy which differ substantially from those policies and procedures which prevailed at the time of approval should be reported to the Secretary of the LCSB for transmittal to the LCSB for action as required.

- E. The LCSB shall submit a report and recommendations to the ABMS and the AMA/CME for consideration by their members within one year after receipt of the application.
- F. The ABMS and the AMA/CME shall independently act on the application after receiving a recommendation for approval from the LCSB. An affirmative vote of two-thirds of the members of each of the ABMS and the AMA/CME, present and voting provided a quorum is present, is required to approve the new board. Each parent of the LCSB shall report its action to the Secretary of the LCSB. If one of the parents disapproves, it must transmit the reasons for disapproval to the LCSB.
- G. If possible, within twelve months of receipt of the application as defined in Section V.C., the LCSB shall inform the petitioning group of its decision.
- H. The petitioner may file a formal appeal in the event of a negative decision by the LCSB. The petitioner must file a written appeal within six months of notification of a negative decision by the LCSB, to the Secretary of the LCSB who will transmit that information to the ABMS and the AMA/CME. The appeal will be heard by a five-person panel consisting of two members of the ABMS Executive Committee who are not members of the LCSB (appointed by the ABMS Executive Committee) and two members of the AMA/CME who are not members of the LCSB (appointed by the AMA/CME). These four individuals will choose a "public member" who may not be a member of the ABMS or the AMA/CME. The appeals panel will review the appeal of the petitioner, include an opportunity for the petitioner to be heard in person, and transmit its recommendations to the LCSB. After considering the recommendations of the appeals panel, the LCSB will take final action on the appeal and will notify both the petitioners and the parents of the LCSB.
- Following approval by the LCSB, the ABMS, and the AMA/CME, the board shall not issue new certificates to individuals who received certification prior to approval without requiring that each meet the same requirements as candidates applying for board certification after approval.

#### Section VI. Meetings of the LCSB

The LCSB shall meet at least annually at the call of the Chairman. On petition of five members of the LCSB, the Chairman shall call a special meeting. The Chairman may also call a special meeting to conduct any business which comes to the attention of the Secretary of the LCSB.

# Section VII. Amendments or Revisions of the Essentials for Approval of Examining Boards in Medical Specialties

Amendments or revisions of the Essentials must be approved by the ABMS and the AMA House of Delegates. Those amendments or revisions which have been approved by two-thirds of the LCSB shall be transmitted by the Secretary to these parent groups for consideration and vote. Changes in the Essentials shall take effect on approval of both the ABMS and the AMA House of Delegates.



### AMERICAN BOARD OF MEDICAL SPECIALTIES®

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August 29, 2005

Thomas R. Gadacz, M.D., F.A.C.S. Governor, American College of Surgeons 4205 Ascot Court Evans, GA 30809

Dear Dr. Gadacz:

The American Board of Medical Specialties® (ABMS) is an organization of medical specialty boards with shared goals and standards related to the certification of medical specialists. Certification includes initial specialty and subspecialty certification and maintenance of certification throughout the physician's career. The mission of the ABMS is to maintain and improve the quality of medical care by assisting the Member Boards in their efforts to develop and utilize professional and educational standards for the certification of physician specialists. The intent of both the initial certification of physicians and the maintenance of certification is to provide assurance to the public that a physician specialist certified by a Member Board of the ABMS has successfully completed an approved educational program and evaluation process which includes components designed to assess the medical knowledge, judgment, professionalism and clinical and communication skills required to provide quality patient care in that specialty. The ABMS serves to coordinate the activities of its Member Boards and to provide information to the public, the government, the profession and its Members concerning issues involving certification of physicians.

According to the ABMS Bylaws (September 23, 2004), the following definitions may prove helpful to you.

(1) "A Medical Specialty is a defined area of medical practice which connotes special knowledge and ability resulting from specialized effort and training in the special field."

Thomas R. Gadacz, M.D., F.A.C.S. Governor, American College of Surgeons August 29, 2005 Page 2

- (2) "A Medical Subspecialty is an identifiable component of a specialty to which a practicing physician may devote a significant proportion of time. Practice in the subspecialty follows special educational experience in addition to that required for general certification. Two different specialty fields may include two or more similar subspecialty areas. In these cases the identified subspecialty area might use the same title and even equivalent educational standards."
- (3) "A Primary Board is a separately incorporated, financially independent body which determines its own requirements and policies for certification, elects its members in accordance with the procedures stipulated in its own bylaws, accepts its candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who voluntarily take and pass its examination."

Clearly the American Board of Surgery (ABS) has been a primary board recognized as a single specialty since 1937. Under the rubric of the ABS are the following subspecialties: Pediatric Surgery, Surgery of the Hand, and Surgical Critical Care. Recently, the ABS was approved to offer a general certificate in Vascular Surgery. However, that being said, the ABS is still recognized as a single specialty.

Sincerety

Stephen H. Miller, M.D., M.P.H.

President

















### American Board of Medical Specialties®









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The American Board of Medical Specialties (ABMS) is the umbrella organization for the 24 approved medical specialty boards in the United States. <u>Established in 1933</u>, the ABMS serves to coordinate the activities of its Member Boards and to provide information to the public, the government, the profession and its Members concerning issues involving specialization and certification in medicine. <u>The mission of the ABMS</u> is to maintain and improve the quality of medical care in the United States by assisting the Member Boards in their efforts to develop and utilize professional and educational standards for the evaluation and certification of physician specialists.

The governing body of each Member Board is comprised of specialists qualified in the specialty represented by the board. The individual Member Boards evaluate physician candidates who voluntarily seek certification by a Member Board of the ABMS. To accomplish this function, the Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements. Physicians who are successful in achieving certification are called diplomates of the respective specialty board. The boards also offer recertification for qualified diplomates at intervals of seven to ten years.

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# American Board of Medical Specialties®









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Allergy & Immunology 510 Walnut Street Suite 1701 Philadelphia, PA 19106-3699 (215) 592-9466 Anesthesiology 4101 Lake Boone Trail Suite 510 Raleigh, NC 27607-7506 (919) 881-2570

<u>Colon & Rectal Surgery</u> 20600 Eureka Road Suite 600 Taylor, MI 48180 (734) 282-9400

Dermatology
Henry Ford Health System
1 Ford Place
Detroit, MI 48202-3450
(313) 874-1088

Emergency Medicine 3000 Coolidge Road East Lansing, MI 48823-6319 (517) 332-4800

<u>Family Medicine</u> 2228 Young Drive Lexington, KY 40505-4294 (859) 269-5626

Internal Medicine
510 Walnut Street, Suite
1700
Philodolphia PA 40406 26

1700 Philadelphia, PA 19106-3699 (215) 446-3500 <u>Medical Genetics</u> 9650 Rockville Pike Bethesda, MD 20814-3998 (301) 634-7315 Neurological Surgery
Suite 2139
6550 Fannin Street
Houston, TX 77030-2701
(713) 441-6015

Nuclear Medicine
4555 Forest Park Blvd., Suite
119
St. Louis MO 62409

St. Louis, MO 63108 (310) 825-6787 Obstetrics & Gynecology 2915 Vine Street, Suite 300 Dallas, TX 75204 (214) 871-1619 Ophthalmology
111 Presidential Blvd, Suite
241
Bala Cynwyd, PA 19004-1075
(610) 664-1175

Orthopaedic Surgery 400 Silver Cedar Court Chapel Hill, NC 27514 (919) 929-7103

<u>Otolaryngology</u> 3050 Post Oak Bivd., Suite 1700 Houston, TX 77056 (713) 850-0399 P.O. Box 25915 Tampa, FL 33622-5915 (813) 286-2444

<u>Pediatrics</u> 111 Silver Cedar Court Chapel Hill, NC 27514-1651 (919) 929-0461 Physical Medicine & Rehabilitation
3015 Allegro Park Lane SW Rochester, MN 55902-4139 (507) 282-1776

Plastic Surgery
Seven Penn Center, Suite 400
1635 Market Street
Philadelphia, PA 19103-2204
(215) 587-9322

<u>Preventive Medicine</u> 330 South Wells Street, Suite 1018 Chicago, IL 60606-7106 (312) 939-2276

<u>Psychiatry & Neurology</u> 500 Lake Cook Road, Suite 335 Deerfield, IL 60015-5249 (847) 945-7900 Radiology
5441 East Williams Blvd.,
Suite 200
Tucson, AZ 85711
(520) 790-2900

<u>Surgery</u> 1617 John F. Kennedy Blvd., Suite 860 Philadelphia, PA 19103-1847 (215) 568-4000

Thoracic Surgery
633 N. St. Clair St., Suite 2320
Chicago, IL 60611
(312) 202-5900

<u>Urology</u> 2216 Ivy Road, Suite 210 Charlottesville, VA 22903 (434) 979-0059

#### ABMS Associate Members

Accreditation Council for Graduate Medical Education 515 North State Street, Suite 2000 Chicago, IL 60610-4322

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Association
One North Franklin
Chicago, IL 60606-3421
(312) 422-3000

(312) 755-5000	(312) 755-7401	
American Medical Association 515 N. State St. Chicago, IL 60610 (312) 464-5000	Association of American Medical <u>Colleges</u> 2450 N Street, N.W. Washington, D.C. 20037-1126 (202) 828- 0400	Council of Medical Specialty Societies 51 Sherwood Terrace, Suite M Lake Bluff, IL 60044-2232 (847) 295-3456
Educational Commission for Foreign Medical Graduates 3624 market Street Philadelphia, PA 19104-2685 (215) 386-5900	Federation of State Medical Boards 400 Fulier Wiser Road, Suite 300 Euless, TX 76039-3855 (817) 571-2949	National Board of Medical Examiners 3750 Market Street Philadelphia, PA 19104-3190 (215) 590-9500

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J. Edward Hill, MD, President

Office of the CHIEF MEDICAL OFFICER

August 31, 2005

LaMar McGinnis, MD c/o American Cancer Society 1599 Cliften Road, NE Atlanta, GA 30329-4251

Dear Dr. McGinnis:

I am writing this letter in response to your e-mail requesting that the American Medical Association (AMA) send you a letter stating that the AMA recognizes general surgery as a medical specialty.

The AMA acknowledges general surgery's status as a distinct medical specialty. In its June 2005 Annual Meeting in Chicago, the AMA's House of Delegates adopted Resolution 317, which requires the AMA to establish policy clearly stating that general surgery is a single specialty, distinct from other surgical specialties. Pursuant to Resolution 317, AMA policy also must state that general surgery should be recognized as a distinct medical specialty by state regulatory agencies. I have attached a copy of Resolution 317 for your reference.

I hope you find this information regarding AMA policy helpful as you develop evidence supporting general surgery as a specialty.

Sincerely.

Edward Hill, MD

Attachment

**HOD Action: Adopted** 

#### AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317

(A-05)

Introduced by:

Georgia Delegation

Subject:

Protecting the Integrity of General Surgery as a Specialty

Referred to:

Reference Committee C

(Harry S. Jonas, MD, Chair)

Whereas, Under Georgia's Certificate of Need Act, physician-owned single specialty ambulatory surgery centers (ASCs) which can be constructed for less than a set capital threshold do not need certificate of need (CON) approval; and

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Whereas, Physician-owned ASCs benefit patients and payers of health care services because they provide high quality care at cost effective rates in convenient locations; and

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Whereas, The Georgia agency responsible for administering the CON program has implemented regulations defining general surgery as a "multi-specialty," thereby automatically disqualifying any general surgeon from opening ASCs without CON approval; and

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Whereas, Many patients needing general surgery care have been precluded from obtaining this care from the physician of their choice at a physician-owned ASC; and

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Whereas. The Georgia Alliance of Community Hospitals has used the legal and regulatory process to stymie the development of physician-owned ASCs and in particular has opposed any efforts to change the rule classifying general surgery as a multi-specialty for CON purposes; and

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Whereas, General surgeons must complete a specialized residency program and are subject to board certification requirements mandated by the American Board of Surgery; and

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Whereas, The practice of general surgery is widely recognized as a single specialty and is one of the twenty-four specialty boards approved by the American Board of Medical Specialties as a specialty unto itself; therefore be it

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RESOLVED, That our American Medical Association establish policy clearly stating that general surgery is a single specialty, distinct from other surgical specialties and that general surgery should be recognized as such by state regulatory agencies. (New HOD Policy)

27 28

Fiscal Note: Staff cost estimated at less than \$500 to implement.

Received: 5/11/05

# Georgia Chapter American College of Surgeons

October 7, 2005

Wm. Lynn Weaver, M.D., F.A.C.S.
President
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Thomas R. Gadacz, M.D., F.A.C.S. 4205 Ascot Court Evans, GA 30809

Re: General Surgery as a Single Specialty

Dear Tom,

At the annual meeting of the Georgia Chapter of the American College of Surgeons which was held at the Cloister on Sea Island, Georgia in September 2005, the issue of general surgery as a single specialty was discussed by the board and in the annual business meeting.

As you are aware, the Georgia Chapter of the American College of Surgeons represents 1,533 active and senior surgeons in the State of Georgia, and serves as the voice of those surgeons who practice and reside in the state.

As president, I have been instructed by the board of directors and the membership to express the Georgia Chapter of the American College of Surgeons' support for general surgery as a single specialty, along with our dismay that general surgery has not been considered a specialty in our state. The recognition of general surgery as a specialty is obvious by its recognition by the American Board of Medical Specialties, the American Medical Association, the American Board of Surgery, the American College of Surgeons, and all of the surgeons who have spent five or more years training for the specialty of general surgery.

It is my hope that this letter in support of general surgery as a single specialty will help in the correction in this obvious oversight in the state of Georgia.

Sincerely,

Wm. Lynn Weaver, MD, FACS

President

/sc

#### GEORGIA SURGICAL SOCIETY

OFFICE OF THE SECRETARY-TREASURER
P.O. BOX 33586

DECATUR (ATLANTA), GEORGIA 30033

THOMAS F. DODSON, M.D. SECRETARY-TREASURER

PHONE 404-727-4137 FAX 404-727-3316 E-MAIL tfdodson@georgiasurgicalsociety.org

September 29, 2005

Thomas R. Gadacz, MD 4205 Ascot Court Evans, Georgia 30809

Dear Dr. Gadacz:

The Georgia Surgical Society, whose membership is approximately 450 and includes all surgical specialties, unanimously supports the reality that general surgery is a single specialty. General surgeons have five years of postgraduate training that does not include other surgical specialties.

At our recent clinical meeting, the four guest speakers all of whom chair nationally and internationally recognized training programs—Duke, Florida, Houston, and Kentucky—were astounded that the state of Georgia does not recognize general surgery to be a single specialty.

Sincerely,

Harry C. Sherman, MD

President, Georgia Surgical Society

HCS:jm



School of Medicine Chairman's Office Department of Surgery

> Hollis Copeland Jenner & Block 1 IBM Plaza Chicago IL 60611

May 16, 2002

#### Dear Ms. Copeland:

This is a letter to affirm the status of General Surgery being a medical and program specialty. Although general is in the title of general surgery, it does not imply that surgeons in this profession are primary care physicians and have no specialty status. Just the opposite is true. The primary care areas designated as generalists include internal medicine, pediatrics and family medicine. These programs are geared to care for patients with various medical problems and the management of acute and chronic diseases. These specialties do not emphasize procedures and deal with the maintenance of patients' health as well as common medical disorders. General surgery specializes in operative treatment of patients. This requires special training and certification.

The term general surgeon refers to surgeons who undergo specialized training. This includes the principal components of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and the endocrine system. It also includes the comprehensive management of trauma, burns, emergency surgery and surgical critical care.

This body of knowledge of diseases and operative procedures related to these categories of diseases characterizes the specialty of general surgery. The training period for a general surgeon, hence to be called surgeon, includes a minimum of five years of residency training. The individuals entering careers and training programs in surgery have successfully completed a college education and four years of medical school. They must have an MD degree before specializing in general surgery. Doctors, who have graduated from medical school, then apply to general surgery residency programs, and if accepted, undergo a minimum of five years of additional training. This training is geared to educate the residents in the essential components of general surgery and must also ensure that they have sufficient fundamentals of knowledge of these diseases, diagnostic interpretation of tests, judgment regarding the indications, the types of operative procedures indicated for various conditions, and the ability to perform the operations on patients and provide post operative care. These individuals must obtain a high level of

technical confidence and skill to perform very complex operations under general as well as local and regional anesthesia.

The education, training and evaluation of the general surgeon are very extensive and exhaustive. At each level of progression during the residency, the faculty and the program director of the residency review the residents. The faculty and program director ensures that the residents are advanced to an appropriate level and also evaluate their clinical and technical skills.

After successful completion of a residency fellowship, the surgeon is required to pass a written examination and if successfully passed, then an oral examination with six examiners is taken to ensure a high level of competency. When both of these examinations are passed, the American Board of Surgery then certifies the surgeon in the specialty of general surgery. Recertification in general surgery is required every ten years to evaluate current knowledge.

General surgery is indeed a specialty and is considered such by every academic and private institution I know. In addition to the training requirements of the American Board of Surgery, general surgery has always been regarded as a specialty service. In practice, including recruiting physicians, credentialing and privileging at hospitals, general surgery has always been considered a specialty practice. Healthcare insurers have always considered surgery a specialty practice as evidenced by reimbursement for specific types of procedures. There is no doubt, general surgery is a specialty and considered as such in many different aspects including career selection, training, certification, practice, credentialing and privileging and reimbursement.

Thomas R. Gadacz, MD, FACS Moretz-Mansberger Professor and Chairman Department of Surgery Medical College of Georgia

Cc. Harry Sherman, MD, FACS
President, Georgia Chapter of the American College of Surgeons

# MINUTES OF MEETING OF HEALTH STRATEGIES COUNCIL

Department of Community Health, Division of Health Planning Greater Macon Chamber of Commerce, 305 Coliseum Drive, Macon, GA 31202 Friday, November 21, 2003

11:00 am - 1:00 pm

#### Daniel W. Rahn, M.D., Chair, Presiding

#### **MEMBERS PRESENT**

William G. "Buck" Baker, Jr., MD Honorable Glenda M. Battle, RN, BSN Harve R. Bauquess David Bedell, DVM Edward J. Bonn, CHE Elizabeth Brock Tary Brown W. Clay Campbell Charlene M. Hanson, Ed.D., FNP (via conference call) Reverend Ike E. Mack Felix Maher, DMD Julia L. Mikell, MD James G. Peak Raymer Martin Sale, Jr. Toby D. Sidman (via conference call) Catherine Slade Oscar S. Spivey, MD Tracy M. Strickland Kurt M. Stuenkel, FACHE

#### **MEMBERS ABSENT**

Anthony J. Braswell
Nelson B. Conger, DMD
Katie B. Foster
Sonia Kuniansky
Honorable Evelyn Turner-Pugh
Katherine L. Wetherbee
David M. Williams, MD

#### **GUESTS PRESENT**

Armando Basarrate, Parker, Hudson, Rainer & Dobbs
Charlotte W. Bedell, Tift County Commissioner
Gayle Evans, Continuum Healthcare Consultants
Sheila Humberstone, Troutman Sanders Public Affairs Group
Jon Howell, GA Nursing Home Association
Joanne Johansen, Savannah Plastic Surgery
Bill Lewis, Phoebe Putney Medical Center
Julia Misen
Brad Robinson
Kevin Rowley, St. Francis Hospital
Temple Sellers, Georgia Hospital Association
Helen Sloat, Nelson Mullins
Christopher Smith, MD, Albany Surgical
Nancy White, Coliseum Health System
Deborah Winegard, Medical Association of Georgia

#### STAFF PRESENT

Kimberly Anderson Commissioner Tim Burgess Charemon Grant, Esq. Richard Greene Ben Robinson Stephanie Taylor

#### WELCOME AND CALL TO ORDER

Dr. Rahn called the meeting of the Health Strategies Council (Council) to order at 11:15 am. He recognized Ed Bonn, Toby Sidman and Charlene Hanson who joined the meeting via conference call. He then called on Richard Greene to welcome Council members and guests. He thanked the Greater Macon Chamber of Commerce for graciously hosting today's meeting. He indicated that the Macon area was part of his senate district when he served in the Georgia General Assembly over 10 years ago. He also welcomed guests to the meeting and encouraged everyone to enjoy the City of Macon and to take advantage of its many local resources, including Georgia Music Hall of Fame, Macon Coliseum and Georgia Sports Hall of Fame. Following his welcome remarks Mr. Greene recognized Charemon Grant, Deputy General Counsel of the Department of Community Health, Stephanie Taylor, Senior Health Planner with the Division and Kim Anderson, Research Analyst in the Division of Health Planning.

The Chair recognized Commissioner Tim Burgess and thanked him for attending today's Council meeting. He further indicated that Nelson Conger contacted him to advise him that he would be unable to attend today's meeting.

#### **REVIEW AND APPROVAL OF MINUTES OF AUGUST 21, 2003**

A motion to accept the minutes of August 21, 2003 was made by Raymer Sale, seconded by Dr. Bedell. The Council unanimously accepted motion.

#### REPORT FROM THE AMBULATORY SURGICAL SERVICES TECHNICAL ADVISORY COMMITTEE

The Chair called on Dr. Baker to present a report of the work of the Ambulatory Surgical Services Technical Advisory Committee (TAC). Dr. Baker recognized and thanked the three members of the Council who served on the TAC namely, Clay Campbell, Raymer Sale and Tary Brown. He said that all members of the TAC should be commended for the time and effort that they have provided to support this effort.

Dr. Baker indicated that the TAC held five spirited meetings from May through November of this year. An opportunity for public comments was offered at each meeting. Also, the TAC hosted a separate Public Forum. During the Public Forum testimony and correspondence was received from a range of constituents. Dr. Baker noted that the last TAC meeting was held on Friday, November 14th. He said that the Attorney General's office did not have a chance to preview the proposed ambulatory surgery services rules prior to their presentation to the Council. Also, he indicated that Department staff have identified several areas which they concur may pose administrative difficulty for the Department and which would require some additional finetuning to ensure consistency of the rules with those of other state agencies. He also noted that the Department has expressed concern about the ability to easily administer the rules in a fair and balanced way. Dr. Baker said that while he had planned to present the proposed ambulatory surgery rules for approval by the Council that he would instead ask for the Council's input. He said that following input from the Council, the Attorney General's office and the Department, the TAC would be reconvened to complete additional work on identified issues. Dr. Baker encouraged Council members to identify issues and to present them at today's meeting or to send identified issues or concerns, in writing, to his attention.

Following Dr. Baker's presentation, the Council engaged in the following discussion:

Dr. Mikell asked for clarification about how the proposed rules differ from the current rules. Also, she asked to have the specific concerns about the proposed rules delineated. Dr. Baker indicated that page five of the proposed plan provides a delineation of the specific differences between the proposed rules and the current rules including the following:

- Expanded and updated definitions:
- Change of terminology from "limited purpose" to "single specialty" and a clear delineation of single specialties;
- Allowance for replacement facilities in narrow situations (exempt from the numerical need methodology and adverse impact standard).
- Incorporation of some straightforward options for exceptions to the numerical need methodology;
- More detailed adverse impact criteria and inclusion of some protections for safety net hospitals; and
- Enhancement of quality, continuity and financial accessibility standards:

Dr. Rahn indicated that the Council was sent the draft plan under separate mailing prior to today's meeting. He asked everyone to review the Department's statement of public policy which appears in the introduction of the draft plan of the proposed Ambulatory Surgery Services plan and which appears below:

The Department of Community Health (DCH) was created in 1999 by the Georgia General Assembly in response to a growing concern about fragmentation of health care delivery at the state level. The legislation outlined several purposes for the Department including the development of a state health care infrastructure that would be more responsive to the consumers it serves while improving access to services and healthcare coverage and promoting wellness. The Department has embarked on this charge with great enthusiasm and fervor. Since the formation of the Department of Community Health, several components of the State Health Plan have been revised to reflect the new regulatory focus and policy integration.

The Department is responsible for managing the state's health planning program which establishes standards and criteria for awarding Certificates-of-Need to health care facilities and certain specialized diagnostic or treatment services. The Department works to contain health care costs by avoiding unnecessary duplication of services, equipment and facilities and helps to enforce quality-of-care standards. The Department is committed to ensuring that providers assume a share of the responsibility for the health care needs of low-income citizens and underserved or at-risk members of their local community. Financial access, clinical proficiency and community outreach are comerstones of the Department's mission.

He further said that the Council's role is to advise the Department on how to carry out its over-arching function with a purpose of improving access, assuring cost-effectiveness and enforcing quality of care standards. He said that all rules should assure that these standards are appropriately addressed. He further indicated that the Council role's is not to advocate a certain model of care, or to advocate for issues with regard to how they would affect provider-owned, for-profit or not-for-profit providers but to provide a balanced approach to plan for the availability of high quality services for all of the residents of the state.

Kurt Stuenkel said that the TAC concluded its work and voted to move its work for presentation to the Council in hopes that it would be presented to the Board of Community Health and issued for public comment. He asked the Chair to clearly identify all of the outstanding issues that need to be revisited by the TAC. He indicated that he has been involved in several technical advisory committees and has never seen the work of a TAC rehashed in this matter.

Dr. Baker indicated that a complete change in the Department's and the Division's administrative staff gave rise to many of the issues that developed in the rule-making process.

Dr. Maher expressed concern about one of the quality of care standards (Section 7-Quality of Care). He indicated that the proposed rules appear to delete general dentistry and other areas of dentistry (i.e. Pediatric dentistry) from the proposed rules. He said that the proposed language might not include general dentistry, periodontics, and orthodontics. He expressed concern that the proposed language may be too restrictive.

Dr. Baker emphasized that the TAC intends to be inclusive so any additional insights would be welcomed and should be sent to the Division, or to his attention, in writing. He said that the Department of Human Resources/Office of Regulatory Services (ORS) has indicated that the word "overnight" should be allowed in the definition of an ambulatory surgery. He indicated that ORS is planning to revisit its current definition of an ambulatory surgery center. The Department and ORS would like to ensure congruency of the rules within state agencies.

Clay Campbell indicated that while there were heated discussions and despite differences about different proposed standards, the TAC ultimately voted to move the proposed rules forward for presentation to the Council and then onward to the Board of Community Health. He said that the TAC's vote represented a huge step forward in the planning process. He expressed concern about reconvening the TAC to rehash many of the issues that already have been deliberated and voted on.

Tary Brown agreed with the position of Mr. Campbell and added that the TAC meetings were very long and intense. He said that lots of data and information was provided and reviewed by the TAC. He indicated that he was very surprised that the proposed rules are being sent back to the TAC.

Julia Mikel indicated her approval of the proposed plan and said that it is still unclear where the identified issues are.

Dr. Rahn called on Richard Greene to identify the specific areas where there are administrative concerns or where the proposed rules are not where they need to be:

Richard Greene indicated that the proposed rules are not to be revisited in their entirety. He said that the Department has to ensure that any proposed language can be clearly interpreted in order to ensure administrative clarity. The Department and the Attorney General's office were specifically concerned about the administration of the rules. He outlined the following areas where there were some concerns:

### APPLICABILITY STANDARD: 272-2-.09(1)(A)(2)(b)

if the service is located in a separate building on the hospital's main campus or on separate premises and the service is integrated with other hospital services and systems, and the services are billed through the hospital's Medicare or Medicaid provider number and/or license number issued by the Department of Human Resources.

Mr. Greene indicated that this standard appears to provide a more lenient standard for hospital applicants. The Office of General Counsel may have difficulty with the interpretation of this section of this standard.

#### DELETION OF USE OF "LIMITED PURPOSE AMBULATORY SURGERY CENTER

Mr. Greene indicated that it is unclear whether the Department can substitute the use of term "limited purpose ambulatory surgery center" with the term "single specialty ambulatory surgery service". While the TAC has indicated that the term limited purpose CON is outdated, the Department continues to issue limited purpose certificates of need. Additionally, at present, there are two legal distinctions between Limited Purpose CON and a single-specialty CON. The Attorney General's office is concerned with the administration of this portion of the proposed rules.

#### DEFINITION OF SINGLE-SPECIALTIES

Mr. Greene said that the Department and the TAC have received lots of correspondence about this standard. Also, he noted that while the TAC has indicated that this list should be used to determine which providers would be eligible to receive a Letter of Nonreviewability, that there is some concern as to whether the list could be used in this manner. The Department would prefer that this language be inserted into O.C.G.A. 31-6-2(14)(G)(iii), rules for Single-Specialty, Physician-Owned Surgical facilities that are exempt from CON regulation.

Dr. Maher expressed concern about the delineation of dental specialties. He indicated that some subspecialties might have been inadvertently excluded.

Dr. Rahn indicated that he has received correspondence from the Medical Association of Georgia (MAG), which was signed by the three physician representatives, who were nominated by MAG and who served on the TAC. This correspondence indicated that the proposed list of single specialties should be expanded.

Dr. Baker indicated that the definition of single-specialties was among the most contentious area that the TAC considered. The list of single-specialties that appears 272-2-.09(1) (b)(16) single specialty ambulatory surgery service (page 4 of draft rules) is different from the current rules. Three additional disciplines have been added (dermatology, neurology, physical medicine and rehabilitation). Dr. Baker noted that the TAC used information from other states, medical associations, information gleaned from the public forum, correspondence to the TAC, the Department's regulatory experience and vigorous committee input to come up with the final list. He noted that the committee also had considered the inclusion of colon and rectal surgery and vascular surgery but TAC members voted to exclude those disciplines from the single specialty list. He said that the TAC had received correspondence from a private physician and a physician group requesting that Interventional Radiology and General Surgery be placed on the list of single specialties. Again, the TAC's vote resulted in the exclusion of these disciplines from the list of single specialties.

Dr. Mikell asked if the single-specialty list should say "neurosurgery" as opposed to "neurology". Dr. Baker indicated that the current list says neurology and that there has been no recommendation to change it. He said that the TAC engaged in significant and extensive debate about the definition of single-specialty and they finally, though not unanimously, agreed to the proposed list. He further noted that The TAC examined materials issued by the American College of General Surgeons (ACGS) which states that "general surgery is a comprehensive discipline that encompasses knowledge and experience common to all surgical specialties" and further that general surgeons have "the experience and training to manage common problems in plastic, thoracic, pediatric, gynecologic, urologic, neurologic, and orthopedic surgery". The Department and many members of the TAC agreed that this statement from the ASGS confirms the wide breath and scope of practice of the general surgeon and supports the contention that general surgery is a multi-specialty discipline. The TAC concurred.

dont

Elizabeth Brock said that she has presided over many TACs and agrees that it is very difficult to reach unanimous decisions. She asked the Council to provide some specific guidance to the TAC about those areas that need to be revisited.

Dr. Rahn summarized Dr. Baker's presentation to the Council noting that the Chair has received input from the Department, providers, and other constituents indicating that there are areas of the proposed rules which may cause some difficulties in administration, and may exclude several disciplines, among other issues. He said that Dr. Baker has asked for the Council's input into the proposed rules since it is the recommendation of the Council that they be sent back to the TAC for further deliberation. He reiterated that the TAC needs to ensure that the standards of the proposed rules capture their intent. He said that each standard does not need to be revisited but where they were expressed concerns by the Department, the Attorney General's office or other constituents, expressed in writing, that the TAC may want to revisit those specific standards. He recommended that the TAC's intent be clearly captured in the corresponding ambulatory surgery services state health plan. He further said that while he has received calls and correspondence from several constituents, that there are some issues that were of concern to him personally, including the following:

- Use of "patients" versus "procedures" in the calculation of the need methodology.
- In the definition of adverse impact, the standard indicates, "a total decrease in ambulatory surgery procedures of 10% or more for any safety net hospital shall be considered detrimental". Dr. Rahn asked if the 10% is a service-specific or a facility-wide measurement and whether the measurement should be "patients" or "procedures" to correspond to the same measurement that is used in the calculation of the need methodology.
- Under the "Quality of Care standard: What is the TAC's expectation about achieving accreditation as opposed to the "intent to meet" accreditation", as described in the proposed standard below. (Must accreditation be achieved? What if accreditation is not achieved?)

An applicant for a new or replacement ambulatory surgery service shall provide a statement of intent to meet, within 12 months of obtaining state licensure, the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAASF) and/or other appropriate accrediting agency.

Dr. Baker indicated that the TAC could address the issue about this quality standard through the issuance of some clarifying language in the corresponding plan about the need for the applicant to submit some proof of having actually received accreditation, subsequent to the issuance of a CON. This information should be provided to the Department in a prescribed manner and within a specified time frame. The TAC would be asked to provide some specific guidance on this issue.

Jim Peak made the recommendation that only those specific areas that are addressed in writing to the TAC be revisited by the TAC for further discussion and deliberation. He made the following motion which was seconded by Elizabeth Brock: Because concerns have been raised by the Department, Attorney General's Office, council members and other constituents, the Chair of the TAC has agreed not to seek approval of the rules today but will seek additional input from the council and will forward only those issues which are

technical, need further congruency among state agencies, need legal clarifications, to the TAC for further deliberation. The council voted on this motion. It passed, though not unanimously.

Cathy Slade asked about the continuity of care standard which states that "an applicant shall demonstrate that the proposed services will be coordinated with the local existing health care system". She asked what this standard is attempting to do. In response, Dr. Baker said that the applicant must ensure that there are local referral relationships in the event that emergency transport is necessary. The applicant would have to provide a Memorandum of Agreement from a local hospital to meet this standard. Ms. Slade recommended the inclusion of some clarifying language in the Ambulatory Surgery Services plan to ensure that the expectations about how to meet this standard are clear to applicants and the Office of General Counsel.

Dr. Rahn thanked members of the TAC for the extensive work that they have undertaken. He particularly thanked and recognized Dr. Baker for his leadership in this important health care area. He reiterated that state policy makers have an interest in ensuring the integrity of the safety net health care system, providing for a plurality of models for healthcare delivery and maintaining access to high quality healthcare in the state. He said that he looks forward to the presentation of the Ambulatory Surgical Services plan and rules at the next Council meeting that is slated for February 2004.

#### DRAFT COUNCIL FY2003 ANNUAL REPORT

The Chair called on Stephanie Taylor to provide an update of the Council's Annual Report. Ms. Taylor said that the draft Annual Report was mailed to all members prior to today's meeting. It describes all of the activities of the Council, including the work of the various technical advisory committees. Members were encouraged to provide verbal comments at today's meeting. She indicated that input could be provided electronically, verbally or by correspondence. The deadline to submit input is November 28th. Ms. Taylor indicated that in addition to Council members, copies of the annual report will be sent to Governor Perdue, Lt. Governor Mark Taylor, Speaker of the House Terry Coleman, Members of the Georgia General Assembly, members of the Board of Community Health and Commissioner Tim Burgess.

### **DEPARTMENT AND DIVISION UPDATES & FY2004 ACTIVITIES**

Dr. Rahn called on Commissioner Burgess to provide an update of the Department's activities. Commissioner Burgess said that he was pleased to be able to attend the Council meeting. He said that the budget process has been consuming a large portion of his time. He further said that the Governor has given the Department some very stringent budget targets to meet. The Department's budget recommendations have been presented to and approved by the Board of Community Health. They will be presented to the General Assembly in January.

Commissioner Burgess said that the Medicaid budget presents the greatest challenge to his administration since expenditures must be reduced by \$441 million dollars, starting in July 2004. He said that the Department would examine several different and balanced approaches. In the past, generally, the Department implemented rate reductions to providers. He said that the magnitude of the budget reductions is too large to consider this option as the sole approach. The Department has proposed recommendations that would affect all of the cost drivers in the system including:

 Price reductions to providers- (including hospitals, nursing homes, physicians, among others). This initiative represents 40% of total budget reductions.

- Scope of practice- (types of services that are available to recipients). Initiatives would include the elimination of some services that are currently available in some programs. At this time, the elimination would be in the category of "optional services"—as defined by the federal government. Reductions in these areas will have an impact on the recipient and include such services as psychological and dental services. This is an area where potential savings can be achieved)
- Utilization-The Department plans to examine and to institute some pilot efforts to control utilization. This area will account for a small portion of budget reductions because it is difficult to control patient behavior in the short-term. The Department also would be undertaking other initiatives including:
  - a. Case management for patients who have high system utilization. The Department will use SOURCE sites around the state for case management purposes. This process will examine 5,000 of the highest Medicaid users (target populations where resource utilization is high) to better control utilization. The Department's emphasis will be how to change utilization patterns to control costs.
  - b. Eligibility- the Commissioner indicated that this area has been seriously overlooked during the cost cutting measures of previous administrations. The Dept. has historically undertaken lots of eligibility expansion in the state. Reductions in eligibility could account for upwards 30%-35% of budget targets. He said that the Department might need to eliminate the "medically needy" category (i.e. nursing home care, eligibility rates for pregnant women). He indicated that this is a very difficult decision, perhaps one of the toughest areas in the budget for the legislature, however the potential cost saving is too large not to consider.

Commissioner Burgess said that the Department has used the budget process as a starting point for discussion with the Governor's office and that the Department will continue to examine some creative ways to control utilization. He acknowledged that there are no easy solutions but the Department will engage many stakeholders in the decision-making process. He said that the Council might be asked to provide input about some of the recommended strategies to address the budget mandates.

Commissioner Burgess further said that the Affiliated Computer Services (ACS) billing system has improved and that the Department has received some assurances from them that the laundry list of outstanding items will be satisfactorily completed by the end of December 2003. He said that their follow-through on identified outstanding items would result in substantial improvements in capability for the state's claims processing and payment system.

Dr. Rahn thanked the Commissioner for his important report. The following remarks and questions followed the Commissioner's report.

Dr. Baker acknowledged that the Department is making several expense reductions. He asked the Commissioner to elaborate on any efforts the Department may undertake to ensure revenue enhancement. Commissioner Burgess indicated that revenue enhancement is not within the purview of the Department. He said that the Governor has not endorsed any such initiatives.

Jim Peak, in comments to the Commissioner, indicated that Indigent Care Trust Fund monies should be administered in a more efficient manner to hospitals, particularly small rural hospitals. He said that the delay in the distribution of these monies is too costly to hospitals.

Glenda Battle, in remarks to the Commissioner, recommended the continued use of existing partnerships at the state and county levels. She indicated that the state should support and strengthen established relationships and should not create any new entities.

Toby Sidman indicated that consumers need to hear all of the issues that are facing the state. She suggested that any partnership opportunities that are recommended include members of organizations, particularly those that Council members are apart of. She said that cancer survivors and providers could benefit from information and collaboration.

Dr. Rahn said that balancing the budget is not an easy task. The consumer fallout is the difficult one. There is a constitutional requirement to balance the budget. The end results could be increases in cost to the health system. Poor health outcomes and increases in infant mortality also could result. He said that the Department should monitor the effects of changes in eligibility. The Department does not have the database to capture this information but it is worth some consideration.

Dr. Rahn thanked Commissioner Burgess for his attendance and participation at today's meeting.

#### **DIVISION UPDATES**

Dr. Rahn called on Richard Greene to provide an update of the Division's work. Mr. Greene clarified that the Division of Health Planning does not rule on CON issues. The Office of General Counsel manages that function. The Division of Health Planning is involved in data collection and policy development. He further said that each of the Council's three standing committees is expected to meet before the next Council meeting and will make recommendations to the Council and the Department about the need to change any of the existing state health plans or rules and would recommend whether it is appropriate to develop regulatory documents for other health care facilities, equipment and services. The three committees are as follows: Long Term Care, Acute Care and Special & Other Services Committees. These committees are chaired by Clay Campbell, David Williams, MD and Kurt Stuenkel, respectively.

#### REPORT FROM THE HEALTHCARE WORKFORCE POLICY ADVISORY COMMITTEE

Dr. Rahn called on Ben Robinson to provide an update on the work of the Healthcare Workforce Policy Advisory Committee. Mr. Robinson said that Charlene Hanson serves on this Committee and represents the Council in an ex-officio capacity. During FY03 the Workforce PAC released its annual report. In it, the Committee acknowledged that the State of Georgia has undertaken a broad array of strategies to remedy workforce shortages. The report further notes that while some measured progress has been made, failure to maintain the proposed initiatives and to commit the needed resources to develop and maintain healthcare professionals could have a devastating impact on Georgia's health care delivery system. He said that while there appears to be some improvement in RN vacancy rates, it is not clear whether this trend would continue into the future or if it would be a short-lived trend. He said that the state anticipates some decline in our adult workforce. Other critical workforce indicators include the following statistics:

o 45% of survey respondents (RN) in a recent statewide survey said that they would be retiring within the next four years. At present, Georgia is experiencing a 7% shortage of nurses. This number is manageable. However, absent any current intervention, by the year 2010, there will be a 40% shortage. This is not manageable and the impact of such a change could be devastating to Georgia communities.

Mr. Robinson further noted that the Workforce Policy Advisory Committee have worked with the University System of Georgia. At present, they are collaborating to assist in the state's workforce planning effort. Further, he said that the Workforce Policy Advisory Committee has recommended the inclusion of \$4.4 into the Intellectual Capital Partnership Program (ICAPP) for the FY2005 budget period. This represents a substantial commitment. The state is seeing some tangible benefits. He called on council members to engage local elected officials in discussions about this critical issue. He indicated that the need for pharmacists in the state also is quite high. At present, there are three schools of pharmacy in the state but no increases in the number of faculty or compensation. These two issues are of primary concern in the field. Mr. Robinson expressed concern about some potentially serious road blocks in the future if the number of needed pharmacy professionals is not realized. He said that healthcare and education go hand in hand. He emphasized that the role and importance of educating elected officials and other policy makers about the importance of securing a viable workforce for the state's present and future healthcare needs.

#### 2004 QUARTERLY MEETING DATES

Dr. Rahn called on Stephanie Taylor to provide information about the dates for the Council's 2004 quarterly meetings. Ms. Taylor indicated that the proposed dates are as follows: February 27, May 21, August 27 and November 19. The May 21st and November 19<sup>th</sup> dates are proposed because the scheduled dates conflict with Memorial Day and the Thanksgiving holidays respectively. The Council voted unanimously to accept the proposed dates. The next Council meeting is scheduled for Friday, February 27th at 2 Peachtree Street, Conference Room 3A&3B on the 7<sup>th</sup> Floor. The meeting will begin at 11:00 am.

Dr. Rahn thanked Dr. Baker and other TAC members for all of the work that they have undertaken during the calendar year. He recognized that several difficult decisions were necessary and many controversial issues were addressed. He reiterated that the Ambulatory Surgical Services TAC needs to revisit several issues. He cautioned the TAC not to revisit all areas of their work but to focus on those areas that the Council has identified during today's meeting.

Dr. Rahn extended Thanksgiving holiday wishes to Council members and guests.

There being no further business, the meeting adjourned at 1:10 pm. Minutes taken on behalf of Chair by Stephanie Taylor.

Respectfully Submitted,

Daniel W. Rahn, MD, Chair

### AMERICAN SOCIETY of GENERAL SURGEONS

ABOUT ASCS. MEMBERSHIP & EDUCATION CALENDAR OF EVENTS SURGICAL PARTNERS LEGISLATIVE ISSUES

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#### **About ASGS: Position Statements**

The Specialty of General Surgery and the Definition of a General Surgeon Specialist

The General Surgeon Specialist is...

A specialist specifically trained and qualified to provide surgical care of the whole patient. The General Surgeon Specialist has expertise in the evaluation and comprehensive treatment Of patients with injuries and illnesses involving a wide range of systems and anatomical regions.

The General Surgeon Specialist, by training, interest, and professional ethics, is dedicated to the total care of the surgical patient and to coordination of the whole episode of care, consulting with other specialists when appropria

The General Surgeon Specialist's areas of major responsibility include comprehensive surgical care of:

- The alimentary tract
- The abdomen and its contents, including the pelvis
- The breast
- The skin, soft tissue and musculoskeletal system
- The chest
- The head and neck
- The vascular system
- The endocrine system
- Oncology
- Trauma
- Critically ill patients.

The General Surgeon Specialist coordinates the patient's surgical care with emphasis on quality, access, and costeffectiveness.

ASGS Board of Trustees Approved April 29, 1995

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#### **CURRICULUM VITAE**

25 September, 2005

Name:

Thomas R. Gadacz, M.D., F.A.C.S.

**Current Position:** 

**Professor Emeritus** 

Medical College of Georgia

Office Address:

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#### **PERSONAL:**

Home Address:

4205 Ascot Court

Evans, GA 30809

Home Telephone:

(706) 650-2025

Date of Birth:

November 23, 1940

Place of Birth:

South Bend, Indiana

Marital Status: Married

Wife: Judith

Children: Audrey born September 9, 1969

Emily born January 2, 1971 Alissa born September 23, 1972 Nicholas born October 14, 1974

#### **EDUCATION:**

1954-58 St. Joseph's High School, South Bend, Indiana

1958-62 University of Notre Dame, B.S., Biology 1962 University of Notre Dame, Graduate School

(6 months)

1962-66 St. Louis University School of Medicine, M.D. 1966-67 University of Chicago, Surgical Internship 1967-68 University of Chicago, Surgical Residency 1970-71 University of California, San Francisco,

Research in G.I. physiology with

Dr. Lawrence Way on "Effects of gastrointestinal hormones on gastric acid secretion and gallbladder contraction."

1971-74 University of California, San Francisco, Surgery Residency

1973-74 University of California, San Francisco, Chief, Surgical Resident

1974-75 Mayo Clinic - Fellow, Gastroenterology, Director, William Summerskill, Clinical research on gastro-intestinal absorption and bile salt metabolism with Drs. S. F. Phillips and A. F.

Hofmann

Board Certification: American Board of Surgery

Date: April 29, 1975

Certificate number: 20886

Medical Licensure:

California - 1970 - 1991

Maryland - 1975 - 1991 Georgia - 1991 - present

**HONORS:** 

Medical School

President of Senior Class

President of Medical Student Council

President of Phi Beta Pi (Medical Fraternity)

Mosby Book Award

Who's Who Among College and University Students

Residency

American Cancer Society Research Fellowship

NIH Training Grant (Surgery), 1970-73

#### Faculty

Young Surgeon Representative from Maryland. American College of Surgeons.

April 13-14, 1980.

VA Commendation - 1985

Leadership VA - 1985

Teacher of the Year Faculty Award, Johns Hopkins, 1990

AOA Member - 1994

Who's Who in Science and Engineering, 2005-2006

Moretz-Mansberger Distinguished Chair of Surgery, 1997 - February, 2004

America's Top Doctors - 2002, 2003 and 2004 Charbonnier Professor February, 2004 - March, 2005

## **MILITARY EXPERIENCE:**

1968-70 United States Navy 1968-69 Naval Hospital, San Diego 1969-70 3rd Marine Division, Vietnam

#### **PROFESSIONAL**:

### Academic Appointments:

September, 2005 – present Feb, 2004 – March, 2005		MEDICAL COLLEGE OF GEORGIA Professor Emeritus Charbonnier Professor of Surgery
1991- February, 2004		Moretz-Mansberger Professor & Chairman Department of Surgery Medical College of Georgia
1991 – August, 2004		Program Director, General Surgery Residency
JOHNS HOPKINS  1992-present Lecturer in Surgery, The Johns Hopkins Hospital  1988-91 Professor of Surgery, The Johns Hopkins Hospital  1979-88 Associate Professor of Surgery, The Johns Hopkins Hospital  1975-78 Assistant Professor of Surgery, The Johns Hopkins Hospital		orgery, The Johns Hopkins Hospital Surgery, The Johns Hopkins Hospital ofessor of Surgery, The Johns Hopkins Hospital
1991-present 1978-91 1975-78	1 Chief, Surgical Service, Baltimore VA Medical Center	
1984-91 1979-84	UNIVERSITY OF MARYLAND, SCHOOL OF MEDICINE Associate Professor of Surgery, University of Maryland School of Medicine Assistant Professor of Surgery, University of Maryland School of Medicine	
1975-91	FRANCIS SCOTT KEY MEDICAL CENTER Visiting Surgeon, Francis Scott Key Medical Center (Baltimore City Hospitals)	

#### **Editorial Boards:**

Current Surgery 2000- present

Surgical Rounds, Editor for Minimally Invasive Surgery

Laparoscopic Surgery, Editor, 1990-93, Decker, Inc.

The Journal of Gastrointestinal Surgery 1996 - 2001

#### Reviewer for the Following Journals:

American College of Surgeons Journal (former SG&O) 1995 - present

American Journal of Surgery 1986 - present

Digestive Diseases and Sciences 1978 - present

Gastroenterology 1984 - present

Hospital Physician 1997 - present

Journal of Gastrointestinal Surgery 1996 - present

Journal of Surgical Research 1980 - present

New England Journal of Medicine 1991- present

Surgery 1975 - present

#### **Professional Organizations:**

American Association for the Study of Liver Disease, 1975 - present

American College of Surgeons, Fellow – 1977 - present

Committee on Surgical Education in Medical Schools (CSEMS)

Continuing Education Committee 1996-99 (Vice-Chairman 1998-1999)

SESAP Committee - SESAP 11 2002-20044

Task Force on Interpersonal and Communication Skills 2002-present

Course Director - Planning Group-Surgeons as Effective Communicators 2002 - present

American Gastroenterological Association, Fellow, 1975 - present

American Pancreatic Study Group, 1975 - present

American Society for Laser Medicine and Surgery, Founding Fellow

American Surgical Association - 1996 - present

Association for Academic Surgery, 1975 - present

Nominating Committee 1978-81

Council Member 1985-87

Association of American Medical Colleges

Association of Program Directors in Surgery, 1983 - 2004

Board member 1998- 2000

Executive Committee 1999-2004

Association for Surgical Education 1991- present

Association of Veterans Administration Surgeons, 1975 - 1991

Baltimore Academy of Surgery, 1975 - 1991

Nominating Committee

1978

Program Chairman

1979-81

Nominating Committee

1983

Secretary

1985-87

Vice-President

1987-88

President

1988-89

Baltimore Liver Group, 1975 - 1991

Eastern Gut Club, 1975 – 1991

Educational Task Force on Interpersonal and Communication Skills, 2002 - present Georgia Chapter, American College of Surgeons

Council member, 1991- present

Governor to ACS 2004 to present

Georgia Gastroenterologic and Endoscopic Society, 1991 - present

Georgia Surgical Society

Council member, 1991 - 2000

Vice President, 2001 - 2002

President, 2002 - 2003

International Society of Surgery

Johns Hopkins Medical Society, 1975 - present

Maryland Chapter, American College of Surgeons, 1978 - 1991

Secretary

1983-85

Vice President 1985-87

President

1987-89

Mayo Alumni Association, 1974 - present

Moretz Surgical Society, 1991 - present

Naffziger Surgical Society, 1974 - present

National Association for Biomedical Research, 1987 - present

Representative of the Society of Surgeons of the Alimentary Tract

National Association of VA Physicians, 1975 - present

Residency Review Committee - Specialist Site Visitor 1979 - 1986

Surgical Residency Programs reviewed:

Buffalo, New York - 1979

Waterbury Hospital, Connecticut - 1983

Abington Hospital, Pennsylvania - 1985

Boston Children's Hospital, Massachusetts - 1986

Society American Gastrointestinal Endoscopic Surgeons (SAGES) - present

Society of Medical Consultants to the Armed Forces

Society of Surgeons of the Alimentary Tract 1975-present

Representative to National Association of Biomedical Research - 1987 - present

Patient Care Committee, Chairman 1995 – 8, member 1995-9

Society of Surgical Chairs 1991-2004

Society of University Surgeons 1980-present

Southeastern Surgical Congress

Councilor-at-large 1993-1996; 1996-1999

Executive Committee 1994-1996; 1996-1998; 1999 - present

Finance Committee 1995-1996; 1999 - present

Clinical Guidelines Committee, 1995 - 2003

First Vice-President 2000 – 2001

President 2002 - 2003

Southern Medical Association

Southern Surgical Association

Program Committee 2003 - 2005

World Association of Hepato-Pancreatic-Biliary Surgery

#### **Institutional Committees:**

Medical College of Georgia:

Graduate Education Committee 1991-2004

Ambulatory Care Access Improvement Joint Task Force

Medical Director, Operative Services 1991 - 2001

Operative Services Executive Committee, Chairman 1991-2001

Finance Committee, Medical College of Georgia Health Inc., 2000 - 2004

Physicians Practice Group:

Board of Trustees 1991-2004

Executive Committee 1991 - 2002

Focus Group on Billing and Collecting, Chairman - 1996 - 1997

Committee on Business Operations - 1997 - 2002

Clinical Enterprise Council Member 1995 - 2004 (chged to

Clinical Leadership Council 8-97)

Clinical Executive Committee

School of Medicine Faculty Senate

Faculty Benefits and Retirement Committee 1994-1997

Deans Committee (VA and MCG) 1991 - 2004

Medical/Dental Staff Executive Committee 1991 - 2004

Hospital Finance Committee 1991 - 2004

Search Committee for Dean, School of Medicine, Member 1993-1994

Search Committee for Chair of OB/GYN, Chairman 1995 - 1996

Search Committee for Chair of Anesthesiology, Chairman 1998-1999

Surgical Chief Leadership Team-Perioperative Services Committee 2001-2004

Chairmen's Committee - Chairman 1997 - 2004

#### Johns Hopkins University:

Surgical Basic Science Course, Director - 1976-78

Surgical Research Seminars, Director 1976-86

Postgraduate Advisor in Surgery 1983-91

Medical Student Clerkship Course in Surgery, Director 1983-91

Curriculum Consultant, Department of Surgery 1983-91

Coordinator, Surgical Residency Program 1983-85

Educational Policy and Curriculum Committee 1983-91

Search Committee for the Garrett Pediatric Surgical Research Chair 1983-85

Executive Committee - Section of Surgical Sciences 1983-91

Medical School Council 1984-88 Clinical Curriculum Subcommittee, Chairman 1987-91

#### Veterans Administration:

Pharmaceutical and Therapeutic Committee 1975-78

Medical Records Committee 1975-78

Commodity Standards 1975-79

Research and Development 1975-86

Blood Banking 1976-78

Professional Standards Board 1977-91

Metabolic Care Committee, Chairman 1977-91

Utilization Review Committee, Chairman 1980-82

Administrative Executive Board 1978-91

Clinical Executive Board 1978-91

District 6 Surgical Committee 1978-91

District 6 Surgical Committee, Chairman 1982-84

District 6 Surgical Committee, Chairman 1985-87

Dean's Committee 1981-91

Equipment Committee - 1982-91

Medical District 6, Planning Board 1982-83

Medical Executive Council 1983-91

Central Office Committee for Ambulatory Surgery Program

Central Office Selection Board for C.O., Chief, Surgical Service

Resource Board 1985-91

#### **ADMINISTRATIVE TRAINING:**

Time Management Seminar - Fred Pryor Seminars - 1979

Leadership VA - 1985. This was a leadership established by Max Clelland for career development and consisted of six one week session throughout the year.

Harvard University Executive Program in Health Program for Chiefs of Clinical Services Policy Management, Harvard School of Public Health, Boston, MA November 9-22, 1980

AAMC Management Education Program. Executive Development Seminar, Marathon, Florida October 25-30, 1991

Medical College of Georgia. Management Retreat. Presented by Career Strategies, Wilnette, Illinois, in Augusta, GA October 1-2, 1992

American College of Surgeons Committee on Operating Room Environment

Baltimore, Maryland May 3-5, 1993

University Hospital Consortium (UHC) Research Conference 1995 Responding to a Dynamic Healthcare Marketplace: Implementations, Strategies for AHC's, Coronado, California January 5-6, 1995

Medical College of Georgia Managed Care Strategic Retreat. Arthur Andersen conducted by Hyatt, Imlour, Ott, and Blount (HIOB) March 22-23, 1995

University Hospital Consortium Operations Improvement. Surgical Services, Benchmarking, meeting and survey results. Coronado, California October 10-11, 1995

University Hospital Consortium Research Conference. Competing in a Maturing Marketplace: A mid-course review. Rancho Mirage, California January 7-8, 1998

Harvard School of Public Health Advanced Program for Chiefs of Clinical Services, Boston, Massachusetts. February 8-13, 1998

#### RESEARCH AND TRAINING GRANTS AWARDED:

1975-76	Veterans Administration RAGS (1 year)
\$20,000	Malabsorption following operation for duodenal ulcer
1976-77	Veterans Administration RAGS
\$15,000	Malabsorption following operation for duodenal ulcer
1976-77 \$1,000	Special research gift (Mr. Lockman)
1977-78	Veterans Administration RAGS
\$17,000	Malabsorption following operation for duodenal ulcer
1978-79	Veterans Administration Merit Review
\$57,000	Effect of vagotomy on the hormone regulation of gallbladder contraction
1978-80	NIH ROI-AM21835-03
\$128,495	Bile composition in post-operative reflux gastritis
1979-85	VA Cooperation Study
\$131,000	Comparison of peritoneo-venous shunt and conventional treatment for ascites in patients with alcoholic cirrhosis. Principal investigator was R.

## A.Baum, M.D.: Surgical Co-investigator was T. R. Gadacz, M.D.

1982 \$1,000	Ayerst Laboratories
1982 \$1,000	Meadox
1983-85 \$126,000	Veterans Administration Merit Review Toxicity studies on cholate and mono-octanoin
1983-84 \$21,000	Ascot Laboratory Comparison of mono-octanoin vs saline infusion into common bile duct of dogs
1983-86 \$73,508	Ayerst Laboratories A comparison of the effect of magaldrate and cimetidine on the prevention of upper gastro-intestinal bleeding in intensive care unit patients.
1985-88 \$204,500	Veterans Administration Merit Review The feasibility and safety of new methods to treat gallstones
1986 \$80,000	G. D. Searle and Company Misoprostol vs antacid in UGI ulcer in surgical ICU patients. Co- investigator with M. Zinner, M.D.
1986 \$73,000	G. D. Searle and Company Misoprostol vs placebo for preventing UGI bleeding recurrence. Co- investigator with M. Zinner, M.D.
1989 \$1,500	Ethitek Pharmaceuticals, Inc. Effect of pH on mono-octanoin stability
1989 \$1,500	Ethitek Pharmaceuticals, Inc. Effect of the rate of mono-octanoin infusion on the pig gallbladder
1992 \$30,000	Georgia Institute of Technology - MCG Grant Surgical Simulator Project
1999 – 2001 \$224,836	United States Department of Energy Grant to develop a laparoscopic Center in Sarov, Russia as a part of the Nuclear Cities Initiative
2003	MCG-UGA (CICP) Grant

#### **PUBLICATIONS:**

- 1. Gadacz TR, Menguy RB: Effects of anti-inflammatory drug oxyphenyl-butazone on the rate of wound healing and biochemical composition of wound tissue. Surgical Forum 18:58-60, 1967.
- 2. Auburn RP, Feldman SA., Gadacz TR: Meconium ileus secondary to partial aplasia of the pancreas: report of a case. Surgery 65:689-693, 1969.
- 3. Menguy RB, Gadacz TR, Zajtchuk R: The surgical management of acute gastric mucosal bleeding. Archives of Surgery 99:198-208, 1969.
- 4. Gadacz TR, Way LW: Comparison of the effect of several gastrin-related compounds on acid secretion in dogs. American Journal of Surgery 123:143-148, 1972.
- 5. Wilson WS, Gadacz TR, Olcott CN, Blaisdell FW: Superficial gastric erosions response to surgical treatment. American Journal of Surgery 126:133-140, 1973.
- 6. Way LW, Gadacz TR, Goldman L: Surgical treatment of chronic pancreatitis. American Journal of Surgery 127:202-209, 1974.
- 7. Gadacz TR, Way LW, Dunphy JE: The changing clinical spectrum of splenic abscess. American Journal of Surgery 128:182-186, 1974.
- 8. Gadacz TR, Allan RN, Mack E, Hofmann AF: Impaired lithocholate sulfation in the Rhesus monkey: a possible mechanism for chenodeoxycholate toxicity. Gastroenterology 70:1125-1129, 1976.
- 9. Gadacz TR, Gainella TS, Phillips S F: Inhibition of water absorption by ricinoleic acid: evidence against hormonal mediation of the effect. American Journal of Digestive Disease 21:859-862, 1976.
- 10. Gadacz TR, Kelly KA, Phillips SF: The continent ileal pouch: absorptive and motor features. Gastroenterology 72:1287-1291, 1977.
- 11. Gadacz TR, Zuidema G D: Bile acid composition in patients with and without symptoms of postoperative reflux gastritis. American Journal of Surgery 135:48-52, 1978.
- 12. Gadacz TR: Effect of an H-2 antagonist on gallbladder contraction. Journal of Surgical Research, 25:334-341, 1978.
- 13. Harmon JW, Doong T, Gadacz TR: Bile salts are not equally damaging to the gastric

mucosa. Surgery 84:79-86, 1978.

- 14. Gadacz TR, Trunkey D, Kieffer RJ, Jr: Visceral vessel erosion with pancreatitis, case reports and a review of the literature. Archives of Surgery, 113:1438-1440, 1978.
- 15. Hutcheon DF, Bayless TM, Gadacz TR: Postcholecystectomy diarrhea. JAMA 241:823-824, 1979.
- 16. Gadacz TR: Efficacy of capmul and the dissolution of biliary stones. Journal of Surgical Research 26:378-380, 1979.
- 17. Ricotta JJ, Schaff HV, Gadacz TR: The effect of aspirin and dipyridamole on the patency of allograft veins. Journal of Surgical Research 26:262-269, 1979.
- 18. Ricotta JJ, Gadacz TR, Kieffer RF, Jr: Intussuseption of the excluded segment following jejunoileal bypass. Johns Hopkins Medical Journal 145:7-9, 1979.
- 19. Pitt HA, Cameron JL, Postier RG, Gadacz TR: Factors affecting mortality in biliary tract disease. American Journal of Surgery 141:66-72, 1981.
- 20. Ricotta J, Zuidema GD, Gadacz TR: Construction of an ileocecal valve and its role in massive resection of the small intestine. Surgery, Gynecology & Obstetrics 152:310-314, 1981.
- 21. Linhardt GE, Jr, Gadacz TR: Prolonged WBC depression after cimetidine in a patient with chronic myelogenous leukemia. Southern Medical Journal 74:353-355, 1981.
- 22. Harmon JW, Lewis CD, Gadacz TR: Bile salt composition and concentration as determinants of canine gastric mucosal injury. Surgery 89:348-354, 1981.
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Gadacz, TR: Surgical considerations of gallstone disease. Audio-Digest Foundation, Volume 44, No 19, October 1, 1997.

## PRESENTATIONS ON HEALTH CARE ISSUES

April, 1989 "The Surgeon's Point of View"

National Conference on HIV '89, McClean, Virginia

April, 1989 "The Politics of Health: A State Response to the AIDS Crises"

American Legislative Exchange Council, Washington, D.C.

Published by Design Communications, 1989.

#### INTERNATIONAL PRESENTATIONS

March, 1987 "Dissolution of Gallstones"

Barcelona, Spain

Erasmus Medical School Rotterdam, Netherlands

Athens, Greece

June, 1987 "Dissolution of Gallstones"

Hepato-Pancreato-Biliary Surgery International

Course and Conference Lund, Sweden

March, 1988 "Fragmentation of Gallstones"

International Meeting on Pathophysiology, Pathophysiology, and

Pathomechanics of the Biliary System

Bologna, Italy

December, 1988 "Gallstone Disease"

Penang Medical Practitioners' Society Penang and Kuala Lumpur, Malaysia

February, 1989 "Treatment of Gallstone and Gallbladder Disease"

7th Congress, Asian Surgical Association

Penang, Malaysia

September, 1992 "Laparoscopic Techniques in the extraction of Common Duct

Stones"

"A Comparison Between Traditional and Laparoscopic

Cholecystectomy"

International Congress on Laparoscopic Surgery

Parma, Italy

November, 1992

"Laparoscopic Common Duct Exploration"

"Placement of Feeding Tube"

"Thoracoscopy"

"Traditional versus Laparoscopic Cholecystectomy"
"Complications of Laparoscopic Cholecystectomy"
Mexico Association of Mexicana de Cirugia General

November, 1995

"New Laparoscopic Procedures"

El-Fayrouz Hospital, Dokki, Giza, Egypt.

## PRESENTATIONS Since 1991

## PRESENTATIONS Thomas R. Gadacz, M.D.

		·
09/06-9/05	Newport, RI	Clinical Performance & Oral Examinations in Surgery
08/01/05	Augusta, GA	Grand Rounds, MCG. Communication Skills for Surgeons: A Competency Requirement
05/21-4, 2005	Chicago, IL	ACS Course: Surgeons As Effective Communicators: Sharpening Skills for Critical Moments
08/23/04	Augusta, GA	Grand Rounds, MCG, Gallstone Pancreatitis
07/28/04	Sea Island, GA	(Medical College of Georgia Continuing Education) "Gallstone Pancreatitis" – Medical and Surgical Approaches to GI Disorders
07/12/04	Augusta, GA	Grand Rounds, MCG. ACGME and the Competencies
06/01/04	Jacksonville, FL	Grand Rounds Shands in Jacksonville, Technology in Surgery
04/23/04	Augusta, GA	Primary Care and Family Practice Symposium – Gallstone Disease in the Elderly
02/13/04	Augusta, GA	Primary Care and Family Practice Symposium – Gallstone Disease in the Elderly
10/03/03	Augusta, GA	GME Program Retreat - MCG Continuing Education "Overview of Resident Duty Hours"
9/10/03	Augusta, GA	(Surgery Grand Rounds, Medical College of Georgia) "Complications of Pancreatitis"
9/3/03	Augusta, GA	(Surgery Grand Rounds, Medical College of Georgia) "The 80 Hour Work Week"
7/23/03	Sea Island, GA	(Medical College of Georgia Continuing Education) "Update in the Management of Common Bile Duct Stones" – Medical and Surgical Approaches to GI Disorders

3/25/03	Augusta, GA	(Medical College of Georgia - Dean's Symposium) "Update on Surgical Technology"
8/6/02	Lawrenceville, GA	(Department of Surgery Grand Rounds, Gwinnett Health System-Gwinnett Medical Center) "Update on Laparoscopic Cholecystectomy"
7/18/02	Sea Island, GA	(Medical College of Georgia Continuing Education) "Gallstone Disease in the Elderly" – Medical and Surgical Approaches to GI Disorders
7/17/02	Sea Island, GA	(Medical College of Georgia Continuing Education) "Complications of Surgery for Reflux Disease" – Medical and Surgical Approaches to GI Disorders
11/16/01	Sea Island, GA	(Georgia Surgical Society) "Technology and Stress" - The Fourth Annual William G. Whittaker, Jr. Lecture
10/19/01	Tampa, FL	(Department of Surgery Grand Rounds, University of South Florida) "The Stress Associated with the Development of Technology"
08/01	Augusta, GA	(Surgery Grand Rounds, Medical College of Georgia) "Establishing a Laparoscopic Center in a Nuclear City in Russia"
07/01	Sea Island, GA	(Medical College of Georgia Continuing Education) "Use of Clinical Pathways in GI Disorders" - Medical & Surgical Approaches to GI Disorders
07/01	Sea Island, GA	(Medical College of Georgia Continuing Education) "Radiation Enteritis" - Medical & Surgical Approaches to GI Disorders
6/8/01	Charlotte, NC	(Department of Surgery Grand Rounds, Carolinas Health Care Systems) "Surgical Technology- The Stress of Staying Current"
02/01	Augusta, GA	(Surgical Grand Rounds, Medical College of Georgia) "Evaluation and Treatment of a Pancreatic Mass"

01/01	Augusta, GA	(Medical College of Georgia Student Surgery Club) "Evaluating Surgical Residency Programs"		
10/00	Chicago, IL	(American College of Surgeons Committee on Surgical Education in Medical Schools) "The Perfect Student"		
10/00	Augusta, GA	(Surgical Grand Rounds, Medical College of Georgia) "Unusual Complications of Pancreatitis"		
09/19/00 Surgeons) "The Challen	Louisville, KY  age of New Technology	(Kentucky Chapter of the American College of		
09/19/00	Louisville, KY	(Kentucky Chapter of the American College of		
Surgeons) "Surgical Management of a Pancreatic Mass"				
09/00 "Preparing fo	Augusta, GA or a Surgical Residency	(Medical College of Georgia Student Surgery Club)		
07/00 Sea Island, GA (Medical College of Georgia Continuing Education) "The Complicated Patient with Biliary Disease" – Medical and Surgical Approaches to GI Disorders				
07/00 "Surgery for	Sea Island, GA Benign Esophageal Di	(Medical College of Georgia Continuing Education) seases" – Medical & Surgical Approaches to GI Disorders		
05/00 "Benign and	Augusta, GA Malignant Diseases of	(Surgical Grand Rounds, Medical College of Georgia) the Esophagus"		
11/99 "Life Cycles	Washington, DC in Chairmanship: The	(Society for Surgical Chairman) First Decade"		
10/99	Orlando, FL	(American College of Surgeons Committee in medical		
schools) "Choosing a Residency Program"				
07/99 "Gastro-esop	Sea Island, GA hageal Reflux Disease	(Moretz Surgical Society) " - Medical & Surgical Approaches to GI Disorders		
07/99 "Achalasia"	Sea Island, GA - Medical & Surgical A	(Medical College of Georgia Continuing Education) Approaches to GI Disorders		

07/99 Sea Island, GA (Medical College of Georgia Continuing Education) "Esophageal Cancer" - Medical and Surgical Approaches to GI Disorders 07/11/98 Augusta, GA (Grand Rounds) "Clinical Pathways and Clinical Guidelines" 02/28/98 Columbia, SC (South Carolina Chapter of the ACS) "What Is New In Laparoscopic Surgery" 10/97 American College of Surgeons Post Graduate Course "Asymptomatic Gallstones: Has the Threshold for Surgery Really Been Lowered?" 06/14/96 Hilton Head, SC (South Carolina Surgical Society) "Treatment of Chronic Pancreatitis: What Factors Influence Surgical Procedures? 06/01/96 Augusta, GA (GI Symposium) "Gallstone Disease Today" 05/31/96 Augusta, GA (GI Symposium)

"Esophageal Reflux"

05/19/96 San Francisco, CA (SSAT) "Advances in Malignant Disease of the Alimentary Tract"

04/24-96) Augusta, GA (Medical-Surgical Nursing) "Pancreatitis"

03/1-3/96 Augusta, GA (Moretz Society) "The Impact of Telemedicine on Surgery Consultations"

09/6-7/95 Baltimore, MD (Grand Rounds) "Advances in Laparoscopic Procedures"

05/23/95 Augusta, GA (Grand Rounds) "Biliary Strictures"

04/19/95 Statesboro, GA (First District Medical Society Meeting) "Innovative Procedures in Laparoscopic Surgery" 03/27/95 Augusta, GA (Gastrointestinal Surgery Conference) "Gastrointestinal Surgery Conference"

03/04/95 Augusta, GA (Moretz Society) "The Future of Technology in Surgical Training"

02/05/95 New Orleans, LA (Southeastern Surgical Conference) "Unusual Laparoscopic & Thoracic Procedures"

01/26/95 Baltimore, MD (Visiting Professor, Union Memorial Hospital) "Complications of Laparoscopic Operation"

11/05/94 Orlando, FL (Southern Medical Association)
"Minimally Invasive Surgery - A Surgical Specialty Approach"

11/04/94 Orlando, FL (Southern Medical Association)
"Complications of Laparoscopic Procedures"

09/08/94 Macon, GA (Visiting Professor, Mercer University)
"Unusual Complications of Pancreatitis"

06/14/94 Chattanooga, TN (Visiting Professor, University of Tennessee) "Innovative Minimally Invasive Procedures" "Approaches to common Duct Stones - Pre-op, Intra-op, and Post-op"

05/12/94 Charleston, SC (23rd Annual Postgraduate Course in Surgery)

"Non- GI Laparascopic Surgery"

"Management of Gastrointestinal Fistulas"

"Transhiatal Esophagectomy for Carcinoma of the Esophagus"

05/16/94 New Orleans, LA (DDW Meetings)
"Randomized Prospective Studies to Evaluate New Laparoscopic Procedures Remains the "Gold Standard" to Assess Safety and Efficacy"

04/11/94 Atlanta, GA (Southern Society of Clinical Surgeons)
"A Multi-disciplinary Approach to Minimally Invasive Surgery"

03/23/94 Sea Island, GA (Meetings of General Surgery Update)
"Innovative Laparoscopic Procedures Involving Surgical Specialties"

03/22/94 Sea Island, GA (Meetings of General Surgery Update)
"Update on Laparoscopic Treatment of Reflux Esophagitis and Inguinal Hernia"

03/05/94 Augusta, GA (Moretz Surgical Society)
"Learning Laparoscopic Procedures as a Resident in Training'

01/19/94 Snowmass, MD (13th Annual Colon & Rectal Seminar)

"Laparoscopic Training in a Surgical Residency"

"Pneumoperitoneum & Diagnostic Laparoscopy"

"Complications of Laparoscopic Operations"

01/18/94 Snowmass, CO (13th Annual Colon & Rectal Seminar) "Colon & Rectal Cancer: Care After Resection:"

11/10/93 Louisville, KY (Louisville Surgical Society)

"Complications of Laparoscopic Surgery"

"Innovative Approaches in Video Assisted Surgery"

10/24/93 Augusta, GA (Georgia Gastroenterologic and Endoscopic Society)
"Management of CBD Stones, Suspected and Documented, in Conjunction with Laparoscopic Cholecystectomy"

10/23/93 Augusta, GA (Georgia Gastroenterologic and Endoscopic Society) "Surgery for Benign Disease of the Pancreas"

10/21/93 Savannah, GA (OR Nursing - Endoscopic Surgery Update) "Future Trends in Laparoscopic Surgery"

10/20/93 Savannah, GA (OR Nursing - Endoscopic Surgery Update)
"The Cutting Edge of Laparoscopic Surgery"

10/09/93 Santa Clara, CA (15th Annual George B. Armanini Surgical Lectures) "Complications of Laparoscopic Surgery"

10/08/93 Mountain View, CA (15th Annual George B. Armanini Surgical Lectures) "Challenging Surgical Problems - Case Presentations"

10/07/93 Menlo Park, GA (15th Annual George B. Armanini Surgical Lectures) "Laparoscopic Approaches to Standard Surgical Procedures"

09/18/93 Sea Island, GA (Annual Meeting of the Georgia Surgical Society)
"Laparoscopic Procedures in Surgical Residency Program"
"Research and Clinical Development in Laparascopic Procedures"

07/07/93 Augusta, GA (Medical College of Georgia, Surgery Ccourse) "Advanced Laparoscopic Techniques in Gastric Surgery"

06/09/93 Hilton Head, SC (General Surgery Update and Review)
"Chronic Pancreatitis - Patients and Operations"
"Esophageal Cancer - Results of Operation for Cure and Palliation"

06/08/93 Hilton Head, SC (General Surgery Update and Review)
"Approach to Common Bile Duct Stones in Patients Undergoing Laparoscopic Cholecystectomy"

04/24/93 New Orleans, LA (Visiting Professor, Tulane University)
"Complications of Laparoscopic Cholecystectomy"", "Laparoscopic Gastrostomy and Jejunostomy"

04/22/93 New Orleans, LA (Visiting Professor, Tulane University) "Laparoscopy and the Common Duct"

04/02/93 Chicago, IL (Visiting Professor, Presbyterian St. Luke Medical Center) "Pancreas Cancer - Role of Resection"

03/20/93 Fort Gordon, GA (Visiting Professor, DDEAMC) "Current Management of Small Bowel Crohn's Disease"

03/06/93 Augusta, GA (William H. Moretz Society)
"What is the Best Type of Laparoscopic Hernia Repair"

11/17/92 Sandersville, GA (Visiting Professor, Washington Memorial) "Laparoscopic/Laser surgery Update)

11/10/92 Mexico (Association of Mexicana de Cirugia General)
"Laparoscopic Common Duct Exploration"
"Placement of Feeding Tube"
"Thoracoscopy"

11/09/92 Mexico (Association of Mexicana de Cirugia General)
"Traditional versus Laparoscopic Cholecystectomy"

"Complications of Laparoscopic Cholecystectomy"

11/05/92 Atlanta, GA (Visiting Professor, Emory University) "Complications of Laparoscopic Surgery"

10/11/92 New Orleans, LA (American College of Surgeons)
"Influence on General Surgery Residency Training"

10/08/92 Hilton Head, SC (13th Annual Frontiers in Nutrition)
"Management of the Nutrition Support Team"
"Surgical Nutrition"

09/21/92 Parma, Italy (International Congress on Laparoscopic Surgery) "Laparoscopic Techniques in the extraction of Common Duct Stones"

"Comparison Between Traditional and Laparoscopic Cholecystectomy"

09/14/92 Bethesda, MD (NIH Meeting)

"Laparoscopic Cholecystectomy" 08/17/92 Augusta, GA (Rotary Club Speaker) "Laparoscopic Surgery: Status of Research and New Product Development" 07/06/92 Milledgeville, GA (Baldwin County Hospital) "Laparoscopic Surgery - Indications, Types and Outcomes" 06/13/92 Fresno, CA (4th Annual Reviews and Advances in Surgery) "Alternatives to Cholecyst: Fragmentation and Dissolution" "Surgery for Gastric and Esophageal Cancer" 06/11/92 Augusta, GA (Defense Attorney Seminar III) "Defending Laparoscopic Cholecystectomy" 05/31/92 Atlanta, GA (Annual Scientific Meeting and Postgraduate Course) "Staging Laparoscopy" 05/15/92 Macon, GA (Annual Day of Surgery, Mercer University) "Operative Indications for Pancreatitis" 04/28/92 Dublin, GA (Visiting Professor, Dublin VAMC) "Laparoscopic Surgery" "Esophageal Cancer" 04/25/92 Columbia, SC (Visiting Professor, University of South Carolina) "Biliary Stricture" 4/16/92 Towson, MD (Visiting Professor, University of Maryland) "Surgery in the Elderly" 04/04/92 Savannah, GA (116 Anniversary Affiliation Celebration) "Opportunities for Collaboration in Graduate Medical Education" 02/19/92 Atlanta, GA (Visiting Professor, Georgia Baptist Medical Center) "Transhiatal Esophagectomy for Esophageal Disease" 02/04/92 Adel, GA (Visiting Professor, Adel Memorial Hospital) "Treatment of Gallstones" 01/20/92 Orlando, FL (Laparoscopy in Diagnosis and Therapy) "Traditional versus Laparoscopic Cholecystectomy"

(Southern Surgical Association)

12/1/91

Hot Springs, VA

"Cholangiography: Current Role in Laparoscopic Cholecystectomy"

10/21/91 Baltimore, MD (American College of Surgeons)

"Current Status of Oral Dissolution Therapy for Gallstones"

10/02/91 Rochester,MI (4th International Symposium on Biliary) "Postcholecystectomy Problems"

09/21/91 Sea Island, GA (Annual Meeting of the Georgia Surgical Society) "Emerging Procedures in Laparscopy and Thoracoscopy"

03/14/91 Columbia, MD (Visiting Professor, Sinai Hospital of Baltimore "Risk Management in the 90's"

01/27/91 Bethesda, MD (Thoracoscopy Course, Military Medical School) "Thoracoscopy in the Animal Model"

## 1 GENERAL SURGERY IS A SINGLE SPECIALTY

THOMAS R. GADACZ, M.D., F.A.C.S.

GOVERNOR FROM GEORGIA
AMERICAN COLLEGE OF SURGEONS

PROFESSOR EMERITUS
DEPARTMENT OF SURGERY
MEDICAL COLLEGE OF GEORGIA

## <sup>2</sup> OUTLINE OF DISCUSSION

MY CREDENTIALS AND EXPERIENCE IN GENERAL SURGERY
DEFINITION OF GENERAL SURGERY
TRAINING OF A GENERAL SURGEON
RECOGNITION OF GENERAL SURGERY AS A SINGLE SPECIALTY
RECOMMENDATIONS

#### <sup>3</sup> ■ CREDENTIALS

St. Louis School of Medicine
University of Chicago – Surgical internship and one year of residency
U.S. Navy – one year in Viet Nam as a Marine Battalion Surgeon
University of California – surgical residency
Mayo Clinic – fellowship in gastroenterology

#### 4 CREDENTIALS

American Board of Surgery – 1975

Johns Hopkins – 1975 to 1991

Professor of Surgery

Chief of VA Medical Center

Medical College of Georgia – 1991 to 2005

Professor and Chairman

Director of Surgical Residency Program

## 5 CREDENTIALS

Trained over 64 general surgeons at Hopkins
Trained 85 general surgeons at MCG
Examined for the American Board of Surgery
Membership in most general surgery organizations and held office in
several
General Surgery Residency Program Director at MCG
Executive Council of the Association of Program Directors in Surgery

## 6 DEFINITION OF GENERAL SURGERY

Specialized training

Principal components

Head and neck

Breast

Skin and soft tissues

Alimentary tract

**Abdomen** 

Vascular system

**Endocrine system** 

### 7 DEFINITION OF GENERAL SURGERY

Includes the comprehensive management of trauma, burns, emergency surgery and surgical critical care

### 8 GENERAL SURGERY TRAINING

College degree with specific science courses

Approved medical school - 4 years of education

Approved general surgical residency program - minimum of 5 years

Certified by the American Board of Surgery

Pass written examination

Pass oral examination

Recertification by ABS every 7 years

# 9 RECOGNITION OF GENERAL SURGERY AS A SINGLE SPECIALTY

Specialized residency training program

**American Board of Surgery** 

Dr. Frank Lewis - Director

American Board of Medical Specialties

Dr. Steven Miller - President

American Medical Association

Dr. J. Edward Hill - President

# 10 RECOGNITION OF GENERAL SURGERY AS A SINGLE SPECIALTY

Georgia Chapter of the American College of Surgeons

Dr. Lynn Weaver - President

Georgia Surgical Association

Dr. Harry Sherman - President

Letter - Dr. Gadacz in 2002

## 11 OTHER SINGLE MEDICAL SPECIALTIES

Orthopedics

Urology

Plastic Surgery

**Thoracic Surgery** 

Colon & Rectal Surgery Anesthesiology

24 SPECIALTIES recognized by the American Board of Medical Specialties (ABMS)

## 12 AREAS OF ADDITIONAL SPECIALIZATION

These are <u>not</u> separate Boards but areas of recognized additional specialization by their primary Board (ABS)

Pediatric Surgery

**Hand Surgery** 

Vascular Surgery

**Surgical Oncology** 

Surgical Critical Care

## 13 HEALTH STRATEGIES COUNCIL

November 21, 2003 – General surgery is a multi-specialty Definition of General Surgery included Plastic Surgery, Urologic, Neurologic, Orthopedic, etc Based on information from ASGS

## 14 American Society of General Surgery (ASGS)

Website definition of General Surgery does not give this definition of general surgery but is in compliance with the definition of General Surgery as defined by the ABS and ABMS (1995)

## 15 RECTIFICATION

Erroneous definition of General Surgery by the Health Strategies Council and the Department of Community Medicine be recognized and corrected for the record

## 16 RECOMMENDATIONS

Go on record as recognizing General Surgery as a single specialty Adopt the definition of General Surgery as defined by the ABS and recognized by the ABMS

Distinguish other Boarded specialties not included under parameters of General Surgery

## 17 RECOMMENDATIONS

Recognition of other medical "specialties" be based on ABMS criteria

CON and other medical strategic planning be based on definitions of medical specialties from well recognized and official medical organizations